



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Health and Recovery Services Administration

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Olympia, Washington 98504-5502

April 23, 2010

Cindy Mann, Director
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

Enclosed is a revised concept paper that would allow Washington State to draw upon the early Medicaid expansion option, afforded under the Patient Protection and Affordability Act, to sustain our Basic Health (BH) and Medical Care Services (MCS) programs until National Health Reform (NHR) is fully implemented in 2014. These two programs will provide a critical coverage bridge for some 90,000 individuals.

Over the past three months, your staff has worked with staff from Washington State to refine Governor Gregoire's original concept paper submitted in January. Our progress was temporarily slowed by the immediate challenge of developing a balanced 2010 supplemental budget for the state, and by the anticipation of increased flexibility available through NHR. With the recent passage of our state budget and NHR, we are now able to direct full attention to the details of a viable partnership with CMS.

We developed the revised concept paper to respond to previous questions raised by your staff and to allow us both to identify remaining issues. I hope it also makes clear that we view the period until full expansion of Medicaid in 2014 as a "dynamic transition." We need federal authority to help sustain the BH and MCS programs over the next 3.5 years, but there is potential for Washington State to increasingly align these programs with the 2014 Medicaid requirements.

The pace of our change will be unavoidably tied to our fiscal recovery and to our managed care procurement cycles. Nonetheless, Washington offers a contained environment for demonstrating applicable new NHR standards and requirements as they evolve, and for addressing potential administrative and systems complexities during the transition to NHR.

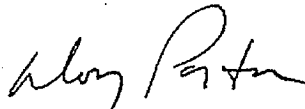
Opportunities are described in more detail in the concept paper and would likely expand as NHR details are clarified, but at this time they include:

- Eligibility determination BH offers a platform to (a) test the new modified adjusted gross income (MAGI) approach to calculating income, and (b) develop an interagency interface that will enable Medicaid systems to seamlessly link with external systems - a requirement of NHR Health Insurance Exchange(s).

- **Benefit design** Through our 2011 managed care contract, beginning January 1, 2011, BH will reach full mental health parity. Further flexibility in the scope of benefits offered in BH and/or MCS will be guided by evolution of standards for coverage in the NHR Medicaid program.
- **Cost-sharing** Fiscal constraints limit our ability to fully adopt current Medicaid requirements and also sustain coverage levels. However, we are obtaining actuarial estimates that will inform the degree to which we can progress. As noted for benefits design we look forward to clarification of NHR standards for cost sharing flexibility.
- **Managed care** Administrative and procurement processes are being reviewed with a goal of increasing the efficiency and consistency of Medicaid, BH, and MCS managed care contracting. During the NHR transition we would bring MCS managed care coverage into full compliance with existing Medicaid requirements. We also would bring BH into compliance with national health insurance reforms as they are clarified. And, although consumer protections are strong because of comprehensive statutory and regulatory managed care requirements, the Medicaid administrative hearings process could be adopted for BH and MCS enrollees.
- **Joint procurement** With Medicaid funding being used to finance the BH and MCS programs, we have an opportunity to engage in joint procurement strategies for our current Medicaid Healthy Options (HO) managed care program and the BH and MCS programs. This may allow us to leverage the purchasing power of HO to support more competitive prices for BH and MCS coverage. It also may lend itself to further adoption of pooling strategies as we transition to NHR in 2014.

We have been very pleased with the courteous and constructive help received from your staff thus far. We look forward to their continued assistance so we can successfully complete our 1115 Demonstration waiver or State Plan Amendment by mid-summer.

Sincerely,



Doug Porter
Assistant Secretary

Enclosure

cc: Susan Dreyfus, Secretary, DSHS
Roger Gantz, Director, HRSA, DSHS
Jenny Hamilton, Program Manager, HRSA, DSHS
Kelly Heilman - CMS Central Office
Steve Hill, Administrator, HCA
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Richard Onizuka, Director, HCA
Jonathan Seib, Senior Policy Analyst, Governor's Office

**REVISED CONCEPT PAPER
SUPPORT FOR A TRANSITIONAL BRIDGE TO NATIONAL HEALTH REFORM
FOR WASHINGTON STATE'S LOW-INCOME ADULTS**

A. Background

Since Washington State's initial January 19, 2010 concept paper, federal and state level fiscal and policy dynamics have caused our State to make several course adjustments. This section recaps our path this year as context for the revised concept paper that follows.

Initial Concept Anticipating Enactment of National Health Reform:

In January 2010, we submitted a concept paper to Secretary Sebelius requesting a federal financing partnership to help sustain the state-funded Basic Health (BH) and Medical Care Services (MCS) programs as a bridge to National Health Reform (NHR). Our assumption at that time was that NHR enactment was imminent using the framework defined by the Patient Protection and Affordable Care Act, (PPACA). Under the PPACA, individuals with family incomes up to 133 percent of the federal poverty level (FPL) were expected to be covered through Medicaid; those with incomes between 133 and 200 percent of the FPL would receive subsidized coverage available in a Health Insurance Exchange or state Basic Health option. Relative to this NHR framework, our concept was seen as a Bridge for individuals who would ultimately become "*new Medicaid eligibles*" but who were facing a potential loss of coverage in the BH and MCS programs as a result of Washington's continuing fiscal crisis¹.

Revised Focus on Caretaker Relatives:

Working with the Centers for Medicare and Medicaid Services (CMS) to understand the possibilities and challenges when NHR appeared stalled, we diverted Washington's concept to target only "*caretaker relatives*" enrolled in BH, with incomes up to 200 percent of the FPL, the upper program limit. We believed that this group, approximately 20,000 citizens, could potentially be eligible for Medicaid financing under a Section 1931 State Plan Amendment (SPA) today. We set about revising our concept paper to target this group, respond to CMS's questions, and remain nimble should NHR actually be enacted.

State Budget Complications:

A new State revenue forecast indicating a \$2.8 billion gap further intensified the State's fiscal crisis beyond that anticipated in our original concept paper. Mid-March, the 2010 Legislature was called back for a Special Session to finalize the 2010 Supplemental budget, which was delivered to the Governor on April 13, 2010, for signature. Following debate on a variety of options for generating the revenue critical to sustaining the BH and MCS programs and funding the budget in general, the current budget (ESSB 6444) includes explicit proviso directives for the Department of Social and Health Services (DSHS) and Health Care Authority (HCA) to seek federal matching funds for the BH and MCS programs through an 1115 demonstration waiver. State funding for both programs is currently assumed through June 2011, with the caveat that if federal funding is not approved the BH program will reduce enrollment below its 65,000 enrollment target and MCS will have to adopt enrollment durational limits².

Enactment of National Health Reform:

Enactment of NHR has brought us full circle. Beginning April 2010, NHR allows States to expand their Medicaid coverage to 133 percent of the FPL. However, for the foreseeable future (through June 2013) Washington State will not have sufficient State funds to support a full Medicaid entitlement expansion. Instead we propose to apply the opportunities available through NHR (and existing SPA expansion options) to the BH and MCS programs.

Transitional Bridge to NHR:

Envisioning that Washington's future coverage infrastructure will build on the platform defined by NHR, our revised goal is to implement a transitional Bridge to NHR based on our existing BH and MCS programs. Consistent with our original concept paper, this would allow low-income individuals enrolled in these programs to sustain coverage until the full expansion of the Medicaid program takes effect in 2014. At that time the majority of these individuals would receive coverage through Medicaid.

By definition Washington's NHR Bridge is time-limited – it ends in January 2014 and effectively covers only about three years. During that time, we propose to use Medicaid funds to cover adults with family income up to 133 percent of the FPL allowing us to continue the BH program at its full scope of coverage up to 200 percent of the FPL³. Subsidies for individuals with incomes between 133 and 200 percent of the FPL would be fully State funded. This approach is integral to our ability to contemplate a role for the NHR state Basic Health option⁴ in Washington's future. As described above in *State Budget Complications*, the 2010 Legislative budget directs BH to reduce enrollment if the NHR Bridge concept is not approved. If that occurred the BH program's ongoing viability would be jeopardized⁵, and we would likely face the prospect of dismantling and subsequently having to rebuild the program and its administrative infrastructure to support a state Basic Health option as part of NHR implementation in 2014. Retaining the MCS program ensures that, even with limited state resources, Washington can continue to provide coverage for its most medically and behaviorally vulnerable adults who are currently not otherwise eligible for Medicaid and Supplement Security Income (SSI).

From a *state* perspective our revised concept gives Washington the flexibility to sustain coverage for at least 90,000 individuals and prepare to implement the *full* range of coverage options under NHR during the transitional Bridge.

From a broader *national* perspective our revised concept offers an early-learning laboratory for CMS to identify and resolve issues that many States will face in preparing for a smooth transition to NHR. It clearly demonstrates the value of NHR as the vehicle for coverage expansion. And it facilitates resolution of operational and system challenges involved in linking multiple subsidized coverage options, an expectation of NHR in 2014. States have little more than three years to get ready. At the same time most are faced with ongoing enormous fiscal challenges and resource constraints. Washington's NHR Bridge jumpstarts the process with a plan to demonstrate NHR standards as they are developed and implemented.